NATIONAL COMMITTEE OF AFRICAN AMERICAN AIDS SERVICE ORGANIZATIONS

[NCAAASO]

GOAL: Create a unified plan of action as it relates to the prevention of HIV Disease in African American communities while improving the quality and longevity of life for those already living with HIV/AIDS

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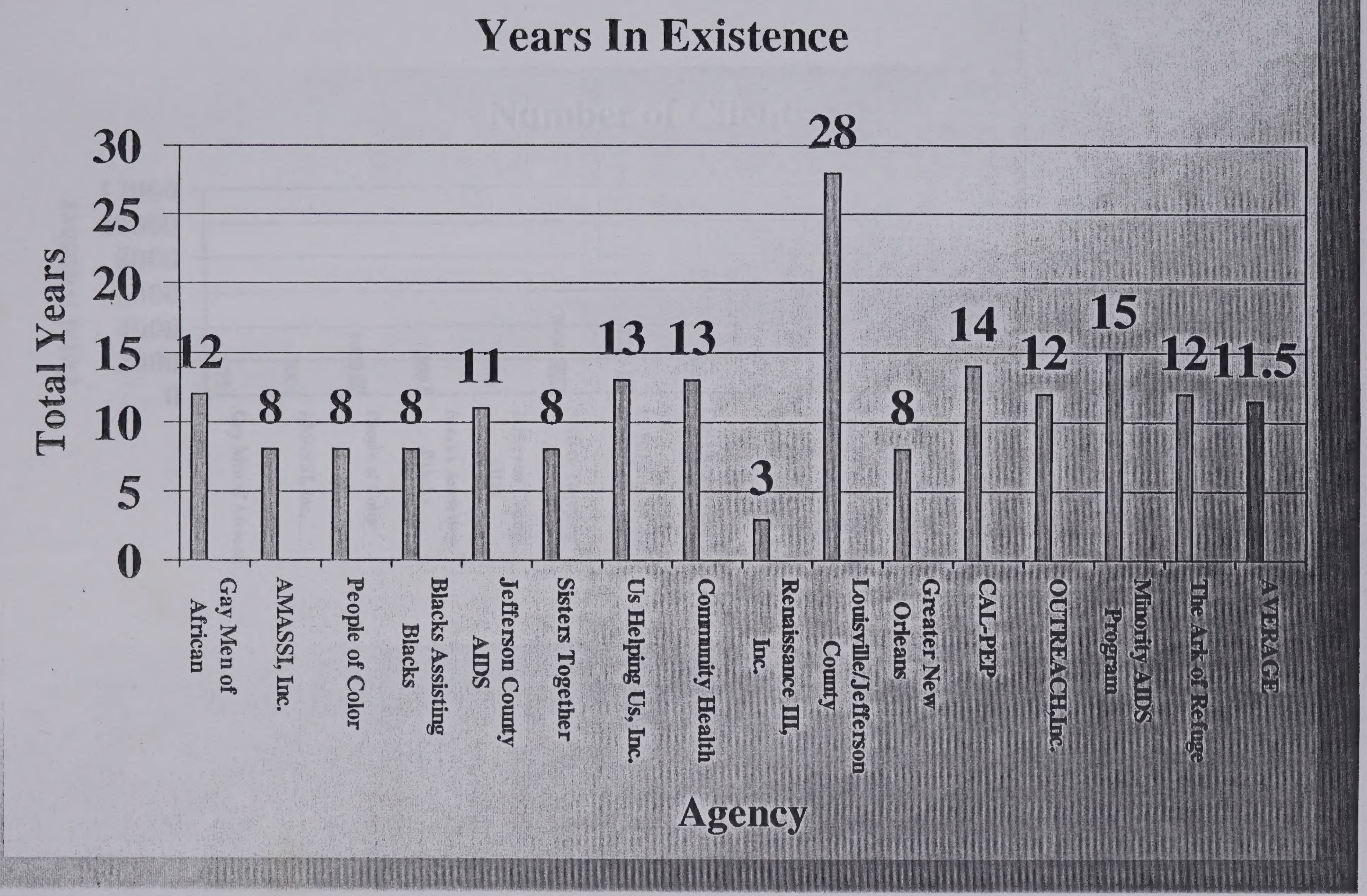
Years In Existence
Total Years
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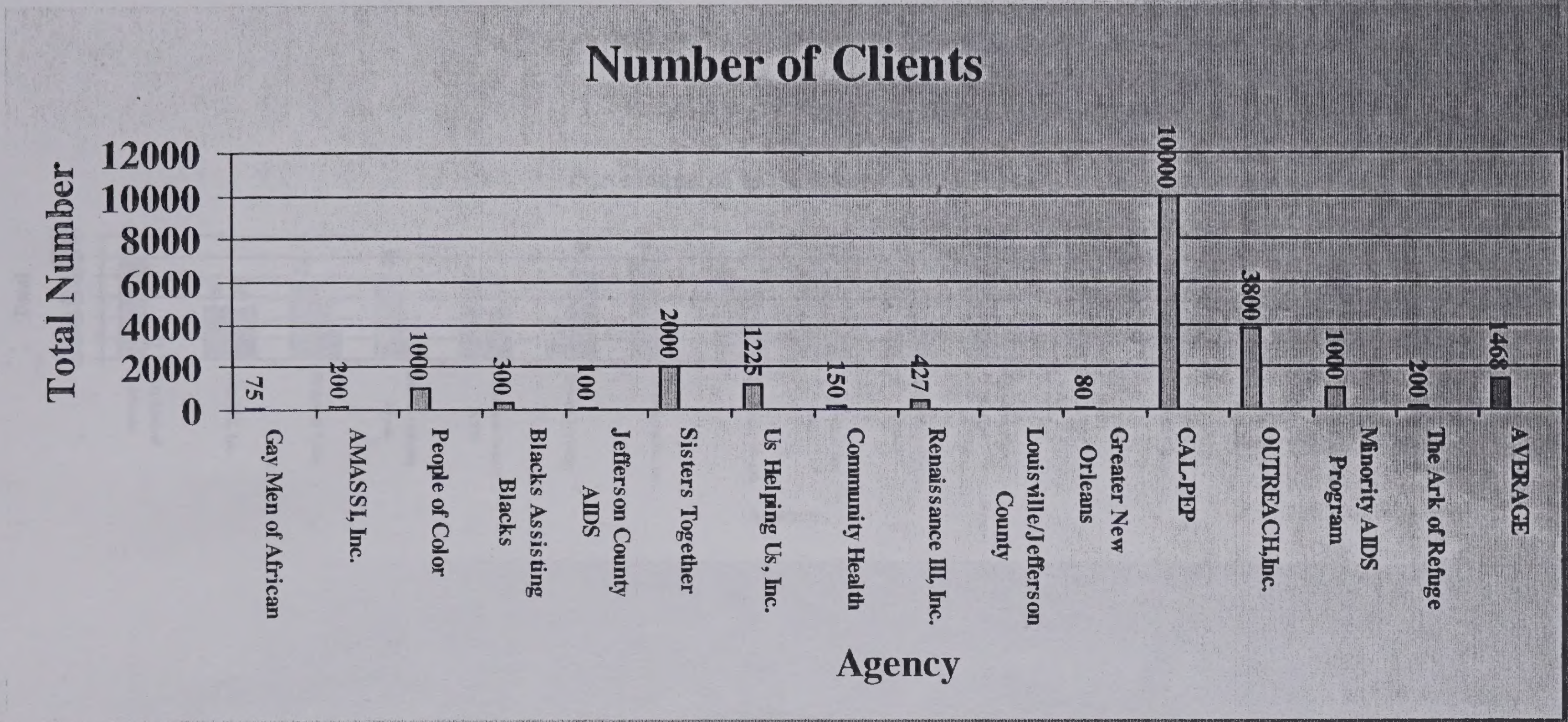
25
20
15
10
5
0
12
8
8
8
11
8
13
13
3
28
8
14
12
15
12
11.5
Gay Men of African
AMASSI, Inc.
People of Color
Blacks Assisting Blacks
Jefferson County AIDS
Sisters Together
Us Helping Us, Inc.
Community Health
Renaissance III, Inc.
Louisville/Jefferson County
Greater New Orleans
CAL-PEP
OUTREACH,Inc.
Minority AIDS Program
The Ark of Refuge
AVERAGE
Agency


Number of Clients
Total Number
12000
10000
8000
6000
4000
2000
0
75
200
1000
300
100
2000
1225
150
427
80
10000
3800
1000
200
1468
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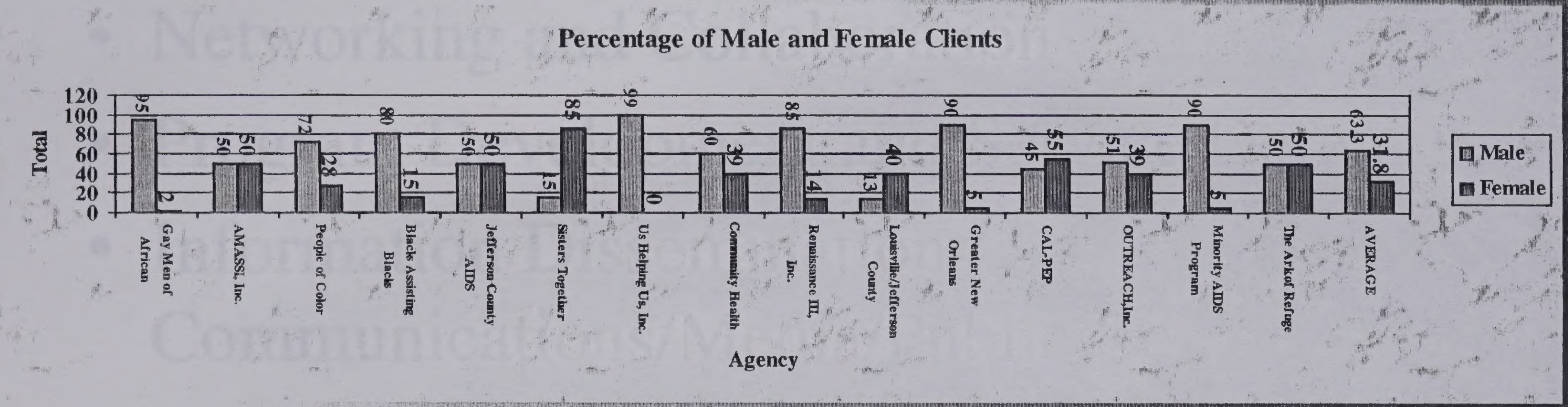
Three Best Practices A
to the Success of

- Networking and Colla
- Information Dissem
- Communications/Media



Three Best Practices Attributed to the Success of the CBO

- Networking and Collaboration
- Program Development and Service Delivery
- Information Dissemination / Communications/Media/Public Relations

Most Common Three Areas CBO Identified for Capacity Building and Technical Assistance

- **Board Development and Training**
- **Volunteer Recruitment and Training**
- **Resource Development/Grant Writing**

Most Common Specific Purposes Additional Funds Are Needed for the CBO's Project

- Operational Expenses
- Additional Staff
- Staff Development and Training

The Major Challenges Faced in Maintaining the CBO

- Funding
- Various Aspects of Employee Recruitment / Training and Performance
- Agency Development and Evaluation

National Committee Of African American AIDS Service Organizations

including Don Snell (Renaissance)

AMASSI, Inc.
351 – 15th Street
Oakland, California 94612-3303
(510) 433-9377 *fax* (510) 835-4206

Executive Director: Alvan Quamina

Summary of Agency's Services:

Services focused on Gay Black Men, HIV+ Housing, Client Advocacy and Housing for Women and Children.

* * *

The Ark of Refuge
1025 Howard Street
San Francisco, California 94103
(415) 861-6100 *fax* (415) 861-6103

Executive Director: Reverend Yvette Flunder
Deputy Director: Valerie Brown-Trout

Summary of Agency's Services:

HIV/AIDS Organizational Activities include Housing Programs and Services, Education, Building Community and Fostering Leadership/Partnership's.

The Balm in Gilead
130 West 42nd Street
New York, New York 10036
(212) 730-7381 *fax* (212) 730 –2551

Executive Director: Pernessa Seele

Summary of Agency's Services:

Activities are focused through religious based organizations to stop the spread of HIV/AIDS in the African American Community and to support those that are infected and affected with and by HIV/AIDS.

* * *

Blacks Assisting Blacks Against AIDS
3115 SouthGrand Blvd., Suite 504
St. Louis, Missouri 63118
(314) 865-1600 *fax* (314 865-2237

Executive Director: Erise Williams

Summary of Agency's Services:

HIV/AIDS Prevention, Education/Outreach, HIV/AIDS Case Management, Support Groups, Transportation, Emergency Assistance and Treatment Education.

CAL-PEP
510 16th Street
Oakland, California 94612
(510) 874-7850 *fax* (510) 839-6775

Executive Director: Gloria Lockett

Summary of Agency's Services:

The Mission of CAL-PEP is to Provide Comprehensive Health Education, HIV/AIDS/STD Prevention, Case Management, Peer and Treatment Advocacy to People Who Are Living With and Affected by HIV/AIDS.

* * *

Community Awareness Group
3028 East Grand Blvd.
Detroit, Michigan 48202
(313) 872-2424 *fax* (313) 872-5546

Executive Director: Harry Simpson

Summary of Agency Services:

Needle Exchange, Street Outreach Counseling and Testing, Case Management, Transportation and Support Groups.

Gay Men of African Descent
248 West 14th Street
New York, New York 10011
(212) 414-9344 *fax* (212) 414-9351

Youth Director: Michael Saunders

Summary of Agency Services:

Education, Social Support, Political Advocacy, Health and Wellness Promotion, Prevention through Discussion Groups, Community Outreach, Community Forums and Seminars.

* * *

Greater New Orleans AIDS Institute
8503 Palmetto Street
New Orleans, Louisiana 70118
(504) 482-1717 *fax* (504) 482-1770

Executive Director: James McDuffie

Summary of Agency Services:

HIV/AIDS Educational Training, Technical Assistance and Workshops to Various Community Agencies, Hospitals and Corporations Developing HIV/AIDS Policies.

Jefferson County AIDS in Minorities
1630 4th Avenue, North
Birmingham, Alabama 35201
(205) 323-7949 *fax* (205) 510-2750

Executive Director: Anthony Morris

Summary of Agency Services:

HIV/AIDS Community Education in Schools, Colleges and Churches, Street Outreach, Group Therapy for African American Gay Men and Substance Abuse Treatment.

* * *

Louisville-Jefferson County
Minority AIDS Program
233 W. Broadway, Suite 120
Louisville, Kentucky 40202
(502) 585-4733 *fax* (502) 585-9648

Executive Director: Stephanie Benson

Summary of Agency Services:

Committed to Risk Reduction, Empowerment Workshops to Churches, Community Centers, Schools and Individual Homes.

Minority AIDS Project
5149 W. Jefferson Blvd.
Los Angeles, California 90016
(323)936-4949 *fax* (323) 936-4973

Executive Director: Bishop Carl Bean

Summary of Agency Services:

HIV Prevention/Education, Support Groups and Faith-Based Counseling

* * *

Outreach, Inc.
825 Cascade Ave., S.W.
Atlanta, Georgia 30311
(404) 755-6700 *fax* (404) 752-9969

Executive Director: Sandra S. McDonald
Deputy Director: Sedrick Gardner

Summary of Agency Services:
HIV/Substance Abuse Programs, Condom Distribution, Peer Counseling, Education and Prevention/Crisis Intervention, Outreach Street Team, Support Groups, Testing, Housing Transportation and Legal Services.

People of Color AIDS Coalition, Inc.
861 Sixth Avenue South
St. Petersburg, Florida 33701
(727) 822-2437 *fax* (727) 896-6122

Executive Director: Carl Devine

Summary of Agency Services:

Information/Educational Referrals, Drop-In Center, Speakers Bureau, Community Outreach, Recreational/Social Activities, Spiritual Programs, Counseling, Caregiver/Family Support Services, Food Bank, Thrift Store, Emergency Assistance, Legal Assistance, Children's Program, Case Management, Substance Abuse Referrals and Support Groups.

* * *

Sisters Together and Reaching (STAR)
1429 McCulloh Street
Baltimore, Maryland 21217
(410) 383-1903 *fax* (4100 383-7856

Executive Director: Deborah Hickman

Summary of Agency Services:

HIV Prevention, Community Outreach, Case Management, Counseling and Financial Assistance.

Us Helping Us, Inc.
811 L. Street, S.E.
Washington, D.C. 20003
(202) 546-8200 *fax* (202) 730-2551

Executive Director: Ron Simmons, Ph.D.

Summary of Agency Services:

HIV Prevention for Black Gay and Bisexual Men, Including Support Groups, Group Therapy, Condom Distribution, Cultural Events, Health Classes, Community Theatre and an HIV Help Line.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

October 5, 1999

Ms. Sandra McDonald
Executive Director
Outreach, Inc.
3030 Campelton Road
Atlanta, GA 30311

Dear ~~Ms. McDonald~~ Sandra:

I'm writing to let you know of important new efforts in the fight against HIV/AIDS in African-American communities.

Today the Centers for Disease Control and Prevention announced the recipients of nearly $40 million in new HIV prevention grants targeted to communities of color. As a result of efforts by the Congressional Black Caucus, CDC received $18 million in new prevention funding for African Americans and $21 million in emergency funding to address prevention needs in communities of color.

To give you the full picture of the more than 100 organizations, cities and states benefiting from these grants, I've enclosed a summary of the types of programs to be funded, and a list of every grantee by state. Grantees are diverse in their approaches and the people they target. Examples of programs funded include:

- The Harlem Congregations for Community Improvement, in New York, a coalition of more than 80 faith-based institutions, will create a community-wide HIV/AIDS Prevention Ministry.
- Blacks Assisting Blacks, in St. Louis, will address the unique needs of African-American gay and bisexual men, including those who may not identify with the gay community.
- Community Action Against Addiction, in Cleveland, will provide HIV testing, counseling and referral services to African Americans who are seeking substance abuse treatment, or who have been diagnosed with another sexually transmitted disease.
- The Center for Haitian Studies will provide HIV counseling and testing to Haitian American young people living in the underserved area of Little Haiti in Miami.
- The Village will provide individual-level HIV prevention for women at risk for HIV infection in St. Croix, Virgin Islands.

While many of the community-based organizations will receive funds to implement new programs, others will use their grants to build the basic services, partnerships, and community infrastructure necessary to implement HIV prevention programs – a major obstacle to effectively reducing HIV transmission in many communities of color.

The recent mobilization by African-American community leaders and the Congressional Black Caucus has helped to dramatically increase the funds available to reach African Americans. In fact, as the enclosed report, *On the Front Lines: Fighting HIV/AIDS in African-American Communities*, makes clear, the amount CDC earmarked for African-American communities has increased by 50% in just one year.

The toll of HIV and AIDS in African-American communities continues. New estimates released by CDC at the National HIV Prevention Conference in August suggest that about one-half of all AIDS cases, deaths, and new infections are believed to occur among African Americans, and AIDS mortality and disease rates remain 10 times higher among blacks than whites.

We urgently need your continued support in raising awareness about HIV/AIDS in communities of color and getting HIV prevention programs to those who need them most. We look forward to developing and continuing our partnership with you in the fight against HIV/AIDS in this country, and to reporting many successes in the future.

If you have any questions, please don't hesitate to call our Office of Communications at 404-639-8890.

Sincerely,

Helene D. Gayle

Helene Gayle, M.D., M.P.H.
Director
National Center for HIV, STD, and TB Prevention

CENTERS FOR DISEASE CONTROL AND PREVENTION

Congressional Black Caucus and Emergency Funds by State

State	Organization	City	Grant Type*	Amount Received ($)
Alabama				
	Birmingham Health Care for the Homeless	Birmingham	CBO	186,071
	Jefferson County AIDS in Minorities	Birmingham	GMOC	182,454
Arizona				
	Arizona Opportunities Industrialization Center	Phoenix	CBA	139,289
	The Ebony House	Phoenix	CBO	181,969
	Native American Community Health Center, Inc.	Phoenix	GMOC	110,000
California				
	United Blackmen of Fresno	Fresno	CBA	116,687
	Bienestar Human Services	Los Angeles	GMOC	200,000
	County of Los Angeles	Los Angeles	CBA	900,000
	Los Angeles County - Office of AIDS	Los Angeles	KYS	469,747
	Minority AIDS Project	Los Angeles	CBO	216,710
	Special Service for Groups	Los Angeles	GMOC	218,218
	Unity Fellowship Church	Los Angeles	Faith	158,334
	African American AIDS Support Services & Survival Institute	Oakland	CBA	175,042
	African American AIDS Support Services & Survival Institute	Oakland	GMOC	200,000
	California Prostitute Education Project	Oakland	CBO	218,824
	National Native American AIDS Prevention	Oakland	GMOC	225,000
	Pacomia Community Youth Culture Center	Pacomia	CBA	156,488
	Logan Heights Family Health Center	San Diego	GMOC	201,492
	Aguilas, Inc.	San Francisco	GMOC	223,792
	The Ark of Refuge	San Francisco	Faith	166,666
	Asian & Pacific Islander Wellness Center	San Francisco	GMOC	225,000
	Black Coalition on AIDS, Inc.	San Francisco	GMOC	200,000
	Iris Center	San Francisco	CBO	220,109
	San Francisco Department of Health	San Francisco	KYS	372,600
	California Department of Health Services	State	Corrections	635,500
	California Department of Health Services	State	KYS	420,000
Colorado				
	People of Color Consortium Against AIDS	Denver	GMOC	153,644

*Grant Types:
CBA - Capacity-Building Activities and Coalition-Building
CBO - Community-Based Organizations
Corrections - Prisons and Jails
GMOC - Gay Men of Color
Faith - Faith Based Organizations
KYS - Know Your Status Campaign

State	Organization	City	Grant Type*	Amount Received ($)
Connecticut	AIDS Interfaith Network, Inc.	New Haven	CBO	168,638
District of Colombia	La Clinica del Pueblo, Inc.	Washington, D.C.	GMOC	195,056
	LLEGO	Washington, D.C.	GMOC	650,000
	Metro Teen AIDS	Washington, D.C.	CBO	221,476
	National Black Alcoholism & Addictions Council	Washington, D.C.	CBA	250,000
	National Black Alcoholism & Addictions Council	Washington, D.C.	Faith	166,667
	Regional Addiction Prevention	Washington, D.C.	CBO	223,284
	Safe Haven Outreach Ministry, Inc.	Washington, D.C.	CBO	220,830
	Us Helping Us, People Into Living, Inc.	Washington, D.C.	GMOC	233,659
Florida	Northwest Behavioral Health Services, Inc.	Jacksonville	CBO	200,000
	Center for Haitian Studies, Inc.	Miami	CBO	83,322
	Greater Bethel A.M.E. Church	Miami	Faith	120,000
	Lock Towns Community Mental Health Center	Miami	CBO	192,274
	Minorities Overcoming the Virus through Education	Miami	CBO	242,500
	Work America, Inc.	Miami	CBO	120,000
	No Longer Bound	Orlando	Faith	158,333
	People of Color AIDS Coalition	St. Petersburg	GMOC	157,263
	Florida Department of Health	State	Corrections	635,500
Georgia	AIDS Education & Services for Minorities, Inc.	Atlanta	GMOC	570,000
	The Interdenominational Theological Center	Atlanta	Faith	300,000
	Health Outreach Project, Inc.	Atlanta	CBO	208,404
	The DeKalb Prevention Alliance, Inc.	Decatur	CBO	215,847
	Our Common Welfare, Inc.	Decatur	CBO	150,744
	Georgia Department of Human Resources	State	Corrections	635,500
Guam	Coral Life Foundation	Hagatna	GMOC	75,000

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State	Organization	City	Grant Type*	Amount Received ($)
Illinois				
	Chicago Center for Health Systems Development	Chicago	Corrections	635,500
	Chicago Women's AIDS Project	Chicago	CBO	197,243
	Circle Family Care	Chicago	CBA	145,685
	City of Chicago	Chicago	CBA	900,000
	Greater Chicago Committee	Chicago	GMOC	233,890
	Sinai Family Health Centers	Chicago	CBA	185,367
	South Side Help Center	Chicago	CBO	100,000
	Southside Help Center	Chicago	CBA	248,000
	Westside Holistic Family Services	Chicago	CBO	219,457
Indiana				
	Indiana Minority Health Coalition	Indianapolis	GMOC	157,600
	Indiana Minority Health Coalition	Marion	CBO	151,556
Louisiana				
	Brotherhood, Inc.	New Orleans	GMOC	77,700
	Brotherhood, Inc.	New Orleans	CBO	222,248
Massachusetts				
	The Multicultural AIDS Coalition, Inc.	Boston	CBA	237,143
	WEATOC, Inc.	Boston	CBO	214,756
	Hampden County Corrections	Ludlow	Corrections	300,000
	Massachusetts Department of Health	State	Corrections	635,500
Maryland				
	Baltimore Prevention Coalition	Baltimore	CBA	186,000
	Black Educational AIDS Project, Inc.	Baltimore	CBO	223,290
	Black Educational AIDS Project, Inc.	Baltimore	GMOC	76,710
	Maryland Department of Health	Baltimore	CBA	900,000
	Northwest Baltimore Corporation	Baltimore	CBA	155,875
	Sacred Zion Church, Inc.	Baltimore	Faith	158,333
	Sisters Together and Reaching	Baltimore	CBO	56,176
	Community Services Coalition	Largo	CBA	120,328
	Maryland Department of Health	State	KYS	250,938

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State	Organization	City	Grant Type*	Amount Received ($)
Michigan	Community Health Awareness Group	Detroit	CBO	222,367
	Community Health Outreach Workers	Detroit	CBA	169,675
	The Detroit Unity Association	Detroit	CBO	210,265
	M.O.C., Play it Safe II	Detroit	GMOC	185,810
Missouri	Blacks Assisting Blacks Against AIDS	St. Louis	CBO	154,275
	Blacks Assisting Blacks Against AIDS	St. Louis	GMOC	178,626
Mississippi	Jackson State University	Jackson	CBA	185,000
	Jackson State University	Jackson	CBA	250,000
	Jackson State University	Jackson	Faith	166,667
	Jackson State University	Jackson	GMOC	380,000
	New Life Ministry, Inc.	Jackson	CBO	196,785
North Carolina	Operation Sickle Cell, Inc.	Fayetteville	CBO	124,382
New Jersey	Liberation in Truth, Unity Fellowship Church	Newark	CBO	210,265
	New Jersey Department of Health and Senior Services	State	Corrections	535,500
New Mexico	People of Color AIDS Foundation	Santa Fe	GMOC	157,600
New York	Brownsville Community Development Corporation	Brooklyn	CBO	218,638
	Haitian Centers Council, Inc.	Brooklyn	CBA	164,300
	Health Watch Information and Promotion Services	Brooklyn	CBA	250,000
	Interfaith Medical Center	Brooklyn	CBA	225,484
	Life Force: Women Fighting AIDS, Inc.	Brooklyn	CBO	164,565
	The Miracle Makers, Inc.	Brooklyn	CBA	231,782
	African Services Committee, Inc.	New York	CBO	223,290
	Association for Drug Abuse Prevention and Treatment	New York	CBO	200,000
	The Balm in Gilead, Inc.	New York	Faith	100,000

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State	Organization	City	Grant Type*	Amount Received ($)
New York (cont'd)	Black Leadership Commission on AIDS, Inc.	New York	CBA	250,000
	Gay Men of African Descent	New York	CBO	88,516
	Gay Men of African Descent	New York	GMOC	250,000
	Harlem Directors Group, Inc.	New York	CBA	244,981
	Harlem Congregations for Community Improvement	New York	Faith	158,333
	Harlem United Community AIDS Center	New York	CBO	216,733
	Harlem United Community AIDS Center	New York	GMOC	83,268
	Hispanic AIDS Forum, Inc.	New York	GMOC	213,543
	Vanguard Urban Improvement Association	New York	CBO	225,000
	Health Research Inc./ New York State Department of Health	State	Corrections	735,500
Ohio	Community Action Against Addiction	Cuyahoga	CBO	196,685
Oklahoma	Urban League of Greater Oklahoma City	Oklahoma City	CBO	189,939
Pennsylvania	The Colours Organization, Inc.	Philadelphia	GMOC	200,000
	Concerned Black Men, Inc.	Philadelphia	CBA	250,000
	Women's Christian Alliance	Philadelphia	CBO	220,000
Puerto Rico	Coai, Inc.	San Juan	GMOC	184,628
Tennessee	Women on Maintaining Education and Nutrition	Brentwood	CBO	196,628
	New Directions, Inc.	Memphis	CBO	161,144
	Metropolitan Interdenominational Church	Nashville	CBA	182,000
Texas	Planned Parenthood Center for El Paso, Inc.	El Paso	GMOC	184,991
	US Mexico Border Health Association	El Paso	GMOC	100,000
	Human Services Network, Inc.	Dallas	CBO	216,128
	Association for the Advancement of Mexican Americans	Houston	GMOC	157,600
	Bread of Life, Inc.	Houston	CBO	132,283
	Families Under Urban and Social Attack, Inc.	Houston	CBO	168,129
	HIV Outreach Prevention Education Project	Houston	CBA	163,284
	BEAT-AIDS, Inc.	San Antonio	GMOC	170,000

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State	Organization	City	Grant Type*	Amount Received ($)
Virgin Islands				
	The Village	St. Croix	CBO	140,000
	Virgin Islands Community AIDS Resource and Education, Inc.	St. Croix	CBO	180,000
	American Red Cross	St. Thomas	CBO	180,000
Wisconsin				
	Black Health Coalition of Wisconsin	Milwaukee	CBA	185,000
	Center for Child and Family Services	Milwaukee	CBA	149,795
	Wisconsin Department of Health	State	KYS	285,775
National				
	National Minority AIDS Council (NMAC)		CBA/Corrections	1,550,000
	Know Your Status Communication Efforts		KYS	2,100,000
	National Testing Day/National Association of People With AIDS (NAPWA)		KYS	250,000
	Testing Infrastructure Assessment Efforts/National Alliance of State and Territorial AIDS Directors (NASTAD)		KYS	550,000
Total Grants				36,472,387
Program Evaluation and Administration				2,527,613
TOTAL AWARDED				**$39,000,000**

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CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION
UPDATE
NCHSTP
National Center for HIV, STD & TB PREVENTION
October 5,1999

CDC Awards $39 Million for HIV Prevention Programs in African-American and Other Communities of Color

Congressional Black Caucus and Emergency Funds Go to Over 100 Organizations

The Centers for Disease Control and Prevention (CDC) has just awarded $39 million to more than 100 organizations throughout the nation to expand HIV prevention efforts in African-American and other communities of color at high risk of infection, including Latinos. The 1999 awards represent a 50% increase in funding earmarked for HIV prevention efforts in African-American communities, when compared to 1998.

African Americans represent an estimated 13% of the total U.S. population, yet are now estimated to account for roughly half of all new HIV infections, AIDS cases and AIDS deaths, according to new data released recently at the first National HIV Prevention Conference. Researchers estimate that 240,000-325,000 African Americans (1 in 50 African-American men and 1 in 160 African-American women) are now infected with HIV. While the numeric toll is not as severe among Latino communities, Latinos are also disproportionately impacted by HIV and AIDS. Latinos represent 11.5% of the U.S. population and are believed to account for 20% of new HIV infections.

As the epidemic has increasingly affected African Americans, an increasing proportion of all of CDC's prevention programs has focused on reaching African Americans at risk, including prevention research to develop effective interventions, systems to monitor the course of the epidemic, and HIV prevention programs in every state and territory across the nation.

In addition to existing efforts, CDC has initiated a number of national, regional, and community-based programs designed exclusively to reach African Americans. Working through state and local health departments and directly funded organizations, CDC initiatives have been built in partnership with the African-American community over time, growing from nearly $11 million in 1988 to $137 million in 1999. These efforts were greatly strengthened last year, when African-American community leaders joined

with the Congressional Black Caucus (CBC) to obtain substantial new prevention funds to address an HIV epidemic that has reached crisis proportions among African Americans.

As a result of these efforts, Congress provided CDC $18 million specifically to fund HIV prevention efforts for African Americans, and $21 million in emergency funding to address prevention needs of African Americans and other communities of color. One-fourth of the emergency funds will be awarded to Latino organizations to begin to expand the services and programs needed to reduce HIV and AIDS in Latino communities at greatest risk.

The majority of new programs will be implemented by community-based organizations funded to deliver HIV prevention programs to high-risk groups and to help communities build the basic services and infrastructure needed to effectively reduce HIV infection. A complete list of grantees by state is available upon request. Specifically, awards have been made to:

- ***47 African-American community-based organizations*** for HIV prevention services targeted to those at greatest risk in communities hard hit by the HIV epidemic **($10 million program).** Examples of programs funded include:
    - The Bread of Life, Inc., will expand HIV counseling and testing services for African Americans who are homeless and at high-risk for HIV infection in Houston.
    - Outreach, Inc., will increase street outreach services, HIV counseling and testing, and access to substance abuse treatment for African Americans in urban Atlanta.
    - Community Action Against Addiction will provide HIV testing, counseling and referral services to African Americans in Cleveland, Ohio who are seeking substance abuse treatment, or who have been diagnosed with another sexually transmitted disease (STD).

  - The Minority AIDS Project in Los Angeles will increase HIV prevention services for African-American bisexual men and their female partners.

- ***34 community-based organizations to reach gay men of color*** **($7 million program).** The majority (about 60% of these programs) are designed to reach African-American gay men, currently the group at highest risk of HIV infection, but several programs have also been initiated to expand and build programs for Hispanic gay men, as well as Native American, and Asian communities of gay men at risk. Examples of newly funded programs include:

  - Brotherhood, Inc., will develop a peer outreach program for African-American gay men in New Orleans.

  - Blacks Assisting Blacks in St. Louis will address the unique needs and barriers for HIV prevention faced by African-American gay and bisexual men, including those who may not identify with the gay community.

  - La Clinica del Pueblo will implement a community-level HIV prevention program to reach Latino and Asian American/Pacific Islander gay and bisexual men in Washington, D.C.

  - The Two Spirit Shields Project in Phoenix will make individual-level prevention the primary focus of their activities targeting Native American gay men.

- ***29 African-American organizations and several hard hit communities to help underserved communities deliver HIV prevention services ($10.5 million program).*** Many of the communities now at greatest risk for HIV lack the basic services, partnerships, and community structures needed to implement HIV prevention programs and to link infected and at-risk individuals to other needed health and social services. In addition to the cities of Baltimore, Los Angeles, and Chicago, examples of organizations that will be working to build this capacity in African-American and other communities include:

    - Jackson State University's Interdisciplinary Alcohol/Drug Studies Center will create a coalition of agencies with longstanding histories of expertise in STD, HIV, TB, and substance abuse prevention to serve African Americans at risk for HIV infection in Jackson, MS.

    - The Interfaith Medical Center, a health care facility serving individuals living with HIV and AIDS, will form a coalition of local service organizations who provide culturally appropriate and multilingual service to African Americans in Brooklyn, NY.

    - The National Black Alcoholism and Addiction Council will assist community-based organizations serving African Americans in New York City, Washington, D.C., Houston, and Orlando in developing plans to generate local support for long-term outreach to individuals at risk for HIV infection in these cities.

- ***10 African-American faith-based organizations to reach African Americans at risk through ministry-based efforts ($1.5 million program).*** Examples of new programs funded include:

    - The Balm in Gilead will provide assistance and training to African-American faith-based organizations in how to effectively participate in their local Prevention Planning Groups (PPGs), which make decisions on HIV prevention activities and funding in their communities.

    - Harlem Congregations for Community Improvement, Inc., a coalition of more than 80 faith-based institutions, will create a community-wide HIV/AIDS Prevention Ministry.

    - The Unity Fellowship Church in Los Angeles will provide HIV prevention services to African-American women who are homeless or who abuse substances.

    - In addition to these efforts, the Interdenominational Theological Center in Atlanta has been funded to develop a training curriculum on HIV prevention to be used in historically black divinity schools.

- ***7 state and city health departments*[1] *to develop HIV prevention programs in correctional facilities to reach high-risk minority populations ($7 million program*[2]*):*** Data released recently at the first National HIV Prevention Conference documented levels of HIV and AIDS among inmates five times higher than the total U.S. population. These data also suggest that nearly one-fifth of all people with HIV and AIDS in 1996 had been released from a correctional facility during that year. While inmates are not typically infected while incarcerated, these facilities provide a unique, but frequently missed opportunity, to reach some of the highest risk populations with HIV prevention and care.

- ***New national efforts to encourage HIV testing among African Americans and others at high risk of HIV infection ($5 million program)***. This effort is part of a broader strategy designed to reduce HIV transmission by reaching people who are infected with HIV but unaware of their status.

These programs represent an important expansion of efforts to reduce the disproportionate and dramatic toll of the epidemic among African Americans. The need to build upon these and other HIV prevention efforts in African-American, Latino, and other communities at risk is greater today than ever before.

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[1] While only 7 health departments will receive direct funding, 11 state and city health departments will collaborate on this program, including: Georgia, Florida, New Jersey, Massachusetts, Illinois and Chicago (combined), California, San Francisco and Los Angeles (combined), and New York and New York City (combined).

[2] This program is a collaborative effort of CDC ($5 million) and the Health Resources & Services Administration ($2 million).

Capacity-Building Assistance (CBA) to Community-Based Organizations Serving African American Populations

CBA Partners Meeting
List of Participants

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National Minority AIDS Council
Capacity Building Assistance Program #99095

Collaborative Partners Meeting Agenda

I. Welcome & Purpose – NMAC & the National Urban League

II. Reflections from Dr. Beny Primm, NMAC Board Chair and Sandra McDonald

III. About the Urban League

IV. Overview of Project Design

- CDC
- NMAC
- Capacity Needs of African American CBO's

V. Role of Collaborative Partners

VI. Project Timeline

VII. Project Evaluation

VIII. Walkthrough of 1st Quarter Deliverables

IX. Benchmark for Today's Meeting/Next Steps

X. USCA Grantee Meetings

Capacity Building Assistance (CBA) to Community Based Organizations Serving African American Populations Heavily Affected by HIV

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Capacity Building Assistance (CBA) to Community Based Organizations Serving African American Populations Heavily Affected by HIV

Program Summary

NMAC's program, briefly summarized, is to collaborate with one national partner, the **National Urban League**, and several regional partners—including the Association of Black Psychologists; Health Watch Information and Promotion Service; Howard University National AIDS Minority Information and Education Program; National Association for Equal Opportunity in Higher Education (NAFEO); Jackson State University National Alumni AIDS Prevention Project; National Council of Negro Women (NCNW); National Alliance of State and Territorial AIDS Directors (NASTAD); National Executive Service Corps; National Prevention Information Network; the Academy for Educational Development (AED) and The Support Center for Non-Profit Management[1]—to develop a **National Capacity-Building Network** constituted by and serving African American CBOs.

The goals of the Network is to work closely with the CDC funded African American CBOs; organize them on a regional basis; comprehensively assess and document their capacity building needs; and offer them a diverse and innovative range of targeted capacity building services. NMAC also proposes very broad leadership roles in the Network by its external stakeholders and partners, including CDC, state and local health departments, regional entities funded under 99095's Category B, and many other African American and AIDS national and regional leadership groups. The rationale underlying this aspect of the program is that all these stakeholders have much to offer the capacity building process themselves, and can learn as much about the actual challenges confronting African American HIV prevention groups in return.

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[1] The designation as a "regional" partner in some of these instances means that the groups cited will take responsibility for helping achieve project objectives within one or more of the specific targeted regions—not that they are not national groups themselves.

Long Term Goals

The National Capacity-Building Network (NCBN) of CBOs serving African American communities will set out to accomplish six broad capacity-building goals:

- **Identify and maintain relationships with CDC funded African American CBOs,** and organize them on a regional basis.
- **Assess, analyze and document the capacity building needs of the target groups in the most comprehensive way possible,** and at several relevant (organizational, regional and national) levels.
- **Provide a highly diverse and innovative range of capacity-building interventions,** utilizing a variety of associated delivery mechanisms and assistance types, to improve the core competencies of the target organizations.
- **Provide mechanisms within the overall capacity-building framework for the target organizations to learn about and assist one another,** and to assume greater ownership of the capacity-building process.
- **Support and enhance the commitment to providing and the coordination of capacity-building assistance among other relevant stakeholders and partners,** including CDC, state/local health departments, regional entities funded under Part B of the 99095 program announcement, National/Regional Minority Organizations (NRMOs) and other African American leadership groups.
- **Evaluate and assess NMAC's efforts as a model** that can provide "lessons learned" to enhance the provision of capacity-building assistance to African American and other AIDS CBOs in the future.

Priority Areas for Capacity-Building Assistance

1. Organizational Infrastructure and Assessment:

- **Fiscal Management**. Establishing a non-profit corporation; ensuring accurate and timely accounting, reporting, bookkeeping, budgeting and forecasting; managing contracts and grants; working with cash flow; maximizing earned income.
- **Resource Development and Grantwriting.** Identifying funding prospects; developing a fundraising plan; making funding requests; writing proposals; building programs for direct mail, special events and individual gifts; conducting stewardship.
- **Board Development.** Reviewing bylaws and procedures; organizing committees; developing board job descriptions; troubleshooting board/staff relations; recruiting, orienting, and retaining new members.
- **Strategic Planning.** Evaluating mission and programs; assessing community needs; identifying opportunities and barriers; pursuing collaboration; retaining new resources; implementing staged organizational and program development efforts.
- **Information Dissemination, Marketing and Public relations.** Identifying key audiences; working with the press; planning culturally appropriate messages and means of communication; developing materials; getting onto the Internet.

2. Intervention Design, Development, Implementation and Evaluation

- **Staff and Volunteer Training and Competency Development.** Assessing staff and volunteer knowledge and skills; finding and disseminating useful information; developing training curricula; using external programs and consultants; measuring professional growth.
- **Planning and implementing Effective Programs**: Identifying population-based needs; targeting program outcomes; planning environmentally, linguistically and culturally appropriate interventions; using behavioral science, epidemiological and research data to enhance intervention effectiveness; conducting a pilot intervention.
- **Evaluation Planning and Implementation.** Deciding what to assess; quantitative and qualitative measurement techniques; collecting relevant information; tabulating and analyzing data; making valid conclusions; applying the results of evaluations to improve program efforts.

The Network will employ the following **Capacity-Building Strategies**:

- **Technical consultation:** Offering expert advice to key personnel about how to accomplish a task or series of tasks.
- **Information transfer:** Collecting, packaging and disseminating useful information.
- **Skills building:** Increasing the skills sets of key personnel.
- **Technical service:** Directly carrying out a task or series of tasks that contribute to organizational capacity building.
- **Technology transfer:** Helping key personnel adopt and use technology, program models, etc. to increase capacity.

Roles of Collaborating Partners

Roles of Collaborating Partners

1. ***National Program Partner:*** The **National Urban League** will be NMAC's *National Program Partner* helping to coordinate and achieve all project objectives throughout each phase of the Network's development, implementation and evaluation. Specifically, the National Urban League will assist in:
    - Coordinating the work of the regional program partners
    - Developing the National Inventory
    - Creating the National Advisory Council
    - Recruiting target organizations into the Network
    - Assess needs and plan appropriate interventions
    - Recruiting consultant pools
    - Planning and providing group and individual level technical assistance
    - Contributing the development of Network publications and Internet content
    - Work with NMAC to benchmark and monitor all project phases
    - Project reporting
    - Conduct project evaluation

2. *Regional Program Partners:* **Association of Black Psychologists, Health Watch Information and Promotion Service, Howard University National AIDS Minority Information and Education Program, Jackson State University National Alumni AIDS Prevention Project, National Association of Equal Opportunity in Higher Education (NAFEO), National Alliance of State and Territorial AIDS Directors (NASTAD), National Prevention Information Network (NPIN), National Council of Negro Women (NCNW), National Executive Service Corps** — The regional Partners will assist with the following:
    - Serving as needed (and as appropriate) on the National Advisory Council
    - Developing the National Inventory
    - Designing and conducting needs assessments
    - Recruiting consultant pools
    - Developing and implementing the regional trainings
    - Providing individual level technical assistance
    - Contribute to project reporting and evaluation

3. *Regional Supporting Program Partners*—**Academy for Educational Development (AED), Support Center for Nonprofit Management.** Their roles will include:
    - Assist with regional training programs
    - Help recruit and develops systems for monitoring consultant pools
    - Help develop Network publications.

Program Plan

Program Plan

Introductory Components

- **Develop a computerized National Inventory of the CDC funded African American HIV/AIDS CBOs. (To Be Discussed with CDC).**

  The Inventory will provide a basis for effective Network recruitment and comprehensive community needs assessment. It may also identify additional resources that can be employed to assist the capacity-building process.

- **Form a National Advisory Council to guide CBA future planning, implementation and evaluation.**

  To help NMAC and its partners plan, guide and evaluate the new Network, NMAC will convene a National Advisory Council, led by its own board chair, Dr. Beny Prim, and constituted of at least twenty other nationally recognized African American HIV/AIDS leaders, with at least three members apiece from each CDC-defined region. A majority of the Council members will represent groups funded by CDC, including the types of groups mentioned under the heading "Involvement of CDC-funded CBOs," above, and groups representing highly affected subpopulations. The Council's primary first year responsibility will be to prepare a comprehensive report to help NMAC evaluate the Network's start-up activities and effectively plan for its future.

- **Develop an ongoing Needs Assessment Component.**

  NMAC has already performed several comprehensive assessments of the capacity-building needs of CBOs serving African American communities. It will develop an ongoing, dedicated Needs Assessment Component within the NCBN itself, however, in order to analyze these needs more closely, identify new ones as they emerge, and further inform the design of the NCBN's capacity-building assistance.

- **Develop and orient the Regional Consulting Pools.**

  Utilizing NMAC's existing national pool of experienced technical assistance consultants, and working with all its collaborative partners, NMAC will identify, recruit and create four new consultant pools, each serving a specific region of the country. Pool members will be professionals with extensive experience responding to one or more of the organizational capacity-building needs targeted by the Network within African American communities.

- **Develop and implement a system for receiving, prioritizing, tracking and responding to Technical Assistance Requests by individual organizations.**

  A substantial part of the Network's interventions will occur in the context of responding to requests for assistance by African American, at times with

multiple kinds of interventions. A fully functional system to receive, prioritize, track and respond to technical assistance requests in a timely fashion already exists at NMAC, and will form the basis for the one adopted by the Network itself.

Implementation /Intervention Components

Implementation /Intervention Components

Implementation/Intervention Components

- **Design, pilot and evaluate the Network's *Individual* Level Interventions:**
  - **Comprehensive Technical Assistance**, defined as a highly deliberate process of individualized organizational needs assessment and intervention that is conducted on-site and primarily utilizes one or more regionally based consultants, and which is initiated over a course of four months and has a specific on-site duration of one to two weeks.
  - **Comprehensive Enhanced Technical Assistance,** the same as the latter but with the inclusion of CDC project officers/local health department personnel as technical consultation/service partners.
  - **Rapid Technical Assistance,** designed to assess and respond to more urgent capacity-building needs within a one and a half month time frame, utilizing regionally based consultants working in conjunction with the Network's staff, and having a specific on-site duration of one to three days.
  - **Technical Assistance on Demand,** to provide emergency capacity-building services within a period of 10 days, using Network staff and consultants and having no specific on-site duration.

- **Design, pilot and evaluate the Network's *Group Level* Interventions:**
  - **Regional Training Programs and inclusion in national conferences.** In its first year, the NCBN will design, pilot and evaluate two dedicated new Regional Training Programs, also based upon the "Taxonomy of Capacity-Building Content Areas" noted above. The first Regional Training Program, addressing the priority needs identified under **Organizational Infrastructure Development and Evaluation,** will target executive directors, senior administrative and board leaders; the second Program, focusing on issues in **Intervention Design, Development, Implementation and Evaluation**, will target executive and program directors and planners. Each Regional Training Program will be three days long, and will be offered in all four regions for up to 60 participants apiece. In addition, NMAC will incorporate Network-specific workshops and seminars into each of its other national conferences, including USCA and CPLS, and develop dedicated scholarship pools in conjunction with those events so that a large number of Network members can attend them.

- **Develop and implement the Network's *Community Level* Interventions:**
  - **Internet, Equal Access Initiative—Computer Grants Program and Publications program components.** ***Internet Component:*** The NCBN will strongly foster the use of the Internet to provide community level capacity-building assistance and to facilitate opportunities for communication between members. Primarily accessible through NMAC's Internet World-Wide Web site at http://www.nmac.org, relevant program

components in the first year will include a dedicated web page that describes the Network and its services; searchable archives of capacity-building manuals and program materials; at least six interactive "Meet the Experts" sessions or other on-line scheduled, capacity-building events; the introduction of biweekly email news digest; a question and answer service; a participant bulletin board; links to collaborative partner web sites; and an on-line, searchable resource guide of other Network participants.

  - **Publications Component:** Finally, the Network will develop and disseminate it own set of publications, including **fax and email-based bulletins and alerts**; a dedicated **quarterly newsletter**, and a **capacity-building manual** on a topic to be selected in association with the results of concurrent needs assessments.

- **Develop and implement strategies for managing ongoing collaboration with program partners.**
  - NMAC and the National Urban League will communicate with network partners on a continuous basis, meet and develop overall workplans and courses of action; and make plans to convene meetings of all the program partners.
  - Discuss and establish strategies for managing all aspects of their collaboration, including the assignment of specific project responsibilities that reflect the MOUs included as a supplement to this request.
  - Partners will continue to convene monthly via conference call to assess progress and identify and overcome obstacles.

- **Effectively coordinate the Network's activities with other national regional stakeholders and partners,** including CDC, 99095 Category B-funded groups, NRMOS, state and local health departments, etc.
  - NMAC and its partners will participate in broader CDC-defined activities to ensure coordination of NCBN activities with those mounted by other organizations and groups, and to share "lessons learned" in a variety of relevant contexts.
  - Participate in several ongoing aspects of the Network's design, development, implementation and evaluation.

Evaluation Components

The overall objective of the evaluation is to try to "capture" the process of launching a national initiative that will be successful in identifying and exposing a representative sample of African American CBO's to a contemporary framework for capacity building. Further it will foster collaborative planning among a diverse group of organizations to achieve a common goal.

Through the planning and implementation stages, NMAC and its partners will evaluate each specific objective and activity, however, listed below are some over arching evaluation strategies.

- NMAC will enhance and create three main organizational components for data generation, collection, and reporting outcomes.
- Provide a check and balance system for evaluation implementation and procedures.
- A top-down and bottom-up approach will be taken to implement outcome monitoring of service delivery and needs assessment analyzes.
- A post evaluation study will be implemented by NMAC to evaluate the distal outcome of the program activities.

Collaborative Partners Meeting

Meeting Notes:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Office of Public Health and Science

Assistant Secretary for Health
Surgeon General
Washington, D.C. 20201

September 17, 1999

Sandra S. McDonald
President & Founder
Outreach, Inc.
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Dear ~~Ms. McDonald~~ Andra:

I am writing on behalf of David Satcher, M.D., the Assistant Secretary for Health and the Surgeon General, to invite your organization to be one of the host sites for The Surgeon General's Minority HIV/AIDS Satellite Teleconference on November 30, 1999. This national satellite video teleconference is designed to broaden the discussion and change attitudes in the African-American and other minority communities about HIV/AIDS. The conference has two major goals--communicate the facts about HIV/AIDS and build partnerships to take the message to all African-Americans.

As you know, HIV/AIDS is the #1 cause of death of young African-American men and women (25-44 years old). And even though death rates from HIV/AIDS are going down in every other population group in the United States, the death rate among African-Americans continues to rise. Out of distrust and fear, many African-Americans discount the warnings and information about HIV/AIDS from the medical establishment and the Federal Government. This distrust has had a deadly effect, preventing many from accepting information, getting tested, seeking treatment, and adhering to treatment.

Communities of color and their leaders have a critical role to play in the fight against HIV/AIDS. To that end, the Surgeon General has established Project LEAD--a community-based, public-private partnership with African-American and other minority leaders. This initiative will provide a range of opportunities for minority leaders to intensify the fight against this devastating disease in the communities where they work and serve. A Project LEAD fact sheet is enclosed to provide additional details on this initiative.

We strongly believe that your organization can play a crucial role. Community-based organizations are strategically positioned to continue to give the African-American community the facts about HIV/AIDS and to encourage people to get tested, seek treatment, and adhere to medication. You have the authority and respect to deliver a vital message to African-Americans about HIV/AIDS. Together we can speak out as leaders to reach African-Americans so more will seek the HIV/AIDS medical treatment they need and reduce the disparity in health care in the United States.

U.S. Public Health Service

Miguel Gomez, Senior Policy Analyst in my office, will contact you by telephone to provide further information and to talk to you about your potential support for this event.

The Department of Health and Human Services will provide funding to assist you and other community-based organizations and participating Historically Black Colleges and Universities' Medical Schools in planning, promoting, and conducting host site conferences preceding the national video teleconference. My office is also working with Morehouse School of Medicine to host a site on campus.

The Surgeon General and I appreciate your steadfast commitment to improving the health of minorities. And, we look forward to working with you on The Surgeon General's Minority HIV/AIDS Teleconference. Please join us, other community-based organizations and the HBCU Medical Schools for the video teleconference. This is an opportunity to make progress in combating HIV/AIDS in the African-American community.

I look forward to your participation in this endeavor.

Sincerely,

Eric P. Goosby, M.D.
Director
Office of HIV/AIDS Policy

Draft Fact-Sheet –(Modified from October 14, 1999)

The Surgeon General's African American Community HIV/AIDS Satellite Conference

The Event: The Surgeon General's African American Community HIV/AIDS Satellite Conference is being convened on behalf of the Surgeon General by the Office of HIV/AIDS Policy. The event will take place on November 30, 1999, from 4:30 – 6:00 p.m. EST. Its goal is very simple: to get across the message of prevention, new drugs, and adherence.

Why Hold the Satellite Conference: We need to get the following messages to the African American and other minority community: HIV/AIDS has a devastating impact on minority communities, and specifically the African American community. Prevention is a tool we can support. We have new drugs to combat the infection: take them and adhere to them.

Hosts: Four Historically Black Colleges and Universities (Meharry, Howard, Drew, and Morehouse) and the Tuskegee Bio-Ethics Institute are hosting the Satellite Conference. (Each school participates as an interactive site as part of the conference.) Community-based AIDS Service Organizations that provide care to African Americans living with HIV/AIDS in these HBCU communities are also hosting this event.

Cosponsors: Cosponsors of the Satellite Conference include members of the Congressional Black Caucus and other members of Congress, and national and local organizations who lend their names, endorse the messages, and may attend a local satellite event.

Target Audience: The target audience is the African American community. This includes community, education, business, faith, civic, and political leaders; public health officials; students, including medical students, and people living with HIV/AIDS. We hope to capture a diverse wider audience that includes those watching the conference on the Surgeon General's Web page and those present at other downlink sites, including those at other colleges, cable stations, schools, AIDS service organizations. etc.

Format of the Event: The conference will link the five primary sites, with one lead host/facilitator. At each site, there will be a site-specific host/facilitator. The Surgeon General will kick-off the satellite conference with a brief message that highlights the conference goals and key messages. Then, at each site, a senior Federal Official will give a brief presentation on prevention, research, care, and adherence. Following this presentation, a person living with HIV will testify about what it means to take the available drugs and adhere to the treatment plan. The presentation will be followed by a question and answer period. The Surgeon General will close the satellite conference with a brief message. There may be a pre- and/or post-conference activity.

For more information, contact Gina Span, Field Coordinator, at BETAH Associates, (301) 657-4254.

Fax

Name:	Sandra S. McDonald
Organization:	President Outreach, Inc.
Fax:	404 752-9969
Phone:	404 755-6700
From:	Nancy Brady
Date:	September 1, 1999
Subject:	HAAC Revised Recommendations
Pages:	9

Attached are the Revisions to the Ryan White CARE Act Recommendations, discussed at the last HRSA AIDS Advisory Committee Meeting held May 13-14 in Rockville, MD

Please review these revisions and fax your comments to me by COB Tuesday September 7. My fax number is 301 594-2835.

On Thursday September 9 from 2:30-3:30 p.m. eastern standard time we will convene a conference call with all HAAC members to discuss any additional comments or changes to the revisions. BETAH Associates will be faxing you information about participating on the call.

We apologize for the quick turn around time, however we are attempting to meet a publications deadline so we can include the Committee's recommendations in HRSA's HIV/AIDS Bureau September Newsletter.

Thank you for your attention to this request.

Our next meeting is October 21-22 at the St. James Hotel in Washington, DC, you will be receiving further information regarding this meeting shortly. We are planning a small reception for the evening of October 20, further information about that will be forthcoming.

Nancy

RYAN WHITE CARE ACT REAUTHORIZATION RECOMMENDATIONS — REVISIONS

Accepted ✔ Rejected ✖

1. Reauthorization of the CARE Act (p. 27-28)

The Ryan White CARE Act should be reauthorized.	✔

2. Structure of the Ryan White CARE Act (p. 28-37)

A reauthorized CARE Act should retain the basic existing title structure, including Title I (Emergency Relief for Areas with Substantial Need for Services), Title II (HIV Care Grants to States), Title III (Early Intervention Services), Title IV (Grants for Coordinated Services and Access to Research for Women, Infants, Children and Youth) and Part F (Special Projects of National Significance, AIDS Education and Training Centers, and Dental Schools). *NB: Concerns about block grants?*	✔

3. Formula issues: Titles I and II (p. 37-39, 49-50, 52-53; 91-94, 95-101, transcript #2)

The legislation should instruct the Secretary of Health and Human Services to consult with appropriate experts and/or to commission a study to explore the implications of various options for developing a new formula method for distribution of CARE funds in the future. Such an undertaking should look at potential use of HIV case data, care provision data, cost data, and other possible methods for distributing funding to meet HIV care needs across the country. *NB: Put on a fast time frame (within 1.5 years of reauthorization) to use results to determine supplemental awards for Titles I & II* (49-50; 101)	✔

4. Hold harmless provisions of formula — Title I and Title II (40+, 47-49, 51, 53; 94-95, 102-114, 116)

Under a reauthorized Ryan White CARE Act, the existing provisions of the law which limit the loss of resources to a jurisdiction over time should be retained, ensuring that no jurisdiction will receive less than 90% of their fiscal year 1995 award in the 2005 fiscal year. *NB: grantee could not lose more than 1% in the ensuing year* (p. 54)	✔

5. Funding distribution — Title II (p. 121-124, transcript #2)

A competitive funding program should be developed within Title II to respond to severe unmet need in states or portions of states. This should be accomplished by setting aside a portion of the national Title II appropriation and making it available for competitive application to states for the development and care delivery activities of consortia outside of Title I EMAs. Legislative authority should be given to HRSA to award these competitive funds based on unmet need and the ability of the applicant to fill gaps in essential services using these funds. (Existing hold harmless language should be retained to insure that this funding comes from new dollars rather than shifting needed services from other states.)	✔

6. Title II — ADAP Formula Distribution (p. 45; 124-128, transcript #2)

While the distribution of ADAP funds in Title II should continue to be based on a case driven formula, a small percentage (up to 10%) of the ADAP appropriation should be made available for award by HRSA based on a competitive application. Priority in awarding these funds should go first to assisting jurisdictions in providing the full range of treatments necessary to meet the PHS treatment guidelines for ~~those with~~ *low* income *persons with HIV* ~~up to 185% of the Federal Poverty Level~~, and then to jurisdictions that will be able to cover additional low income individuals. Part of the competition may be used to provide incentive to jurisdictions to make state/local funding available for this purpose or to enhance their state Medicaid eligibility guidelines.	✓

7. Statewide Coordinated Statement of Need

In addition to those partners specified in the existing legislation (individuals with HIV, representatives of grantees under each part of this title, providers, and public agency representatives), the legislative requirement for a periodic meeting to develop a statewide coordinated statement of need should also specify the desirability of participation of other publicly-funded agencies serving vulnerable populations (MCH, Health Care for the Homeless, Medicaid, Medicare, mental health and substance abuse services, Indian Health Service, HOPWA, CDC-supported counseling/testing, prevention and outreach programs, corrections and probation, youth serving agencies, and other similar relevant providers).	?

8. Title I Planning Councils — Composition (p.93-132; 195-197, transcript #2)

The legislative language concerning composition of the planning councils should be strengthened to require that the composition of the planning council reflect the racial/ethnic and risk factor demographics of the local epidemic, and that consumer representation should reflect the same characteristics. Demonstration of this should be a requirement of funding under this section of the act. Additionally, language should be added specifically ~~encouraging~~ to ensure representation of women, youth, substance abusers, *gay men, adolescents*, and people of color living with HIV.	✓
The legislation should mandate that a minimum of 33% of the members of planning councils should be people living with HIV.	✓
In addition to the representation of provider groups currently outlined in the legislation, the CARE Act should also encourage inclusion of corrections and probation agencies, homeless and housing groups, youth advocates, nurses, social workers, *gay and lesbian organizations*, and other agencies serving vulnerable and affected populations.	✓
The legislation should ~~specifically allow the~~ *require planning councils to provide training to support consumer participation on planning councils and allow* expenditures ~~of funds~~ to support *consumers' training and* participation ~~of consumers in planning councils~~, including payment for necessary expenses such as child care, transportation, hotels and meals, as well as reasonable stipends for time participating in planning activities.	✓
At majority (at least 51%) of planning council members must be free of conflict, as defined by the current legislation.	✓

9. Title II — Participatory planning (p. 132-137)

Within Title II of a reauthorized Ryan White CARE Act, e recommend that a legislative mandate be created for an open advisory planning process that includes people living with HIV and a range of representatives from affected communities and service providers. States receiving Title II funds should be required to demonstrate that such a participatory process exists and is consulted in decisions about needs assessment and priority setting for Title II funds. Consortia funded through Title II of the CARE Act should be required to demonstrate that their membership includes representation reflecting the epidemiology of HIV/AIDS in their geographic area and includes people living with HIV/AIDS as well as providers of services to impacted populations. Consortia should be required to conduct open nomination processes and to conduct open business meetings.	✓

10. PHS guidelines as priority for CARE Act services (p. 138, 144-153)

Implementation of Public Health Service Guidelines (PHS) for HIV treatment and care should be a priority for grantees. As a condition of award, all CARE Act grantees ~~under all Titles of a reauthorized Ryan White CARE Act~~ should be required to document the specific steps they are taking to ensure that people living with HIV in their area of service are receiving care that meets or exceeds PHS guidelines ~~for HIV treatment and care.~~	✓

11. Priority to core services and linkages to health care (p. 139-140, 153-159)

A reauthorized Ryan White CARE Act should instruct grantees to prioritize, as appropriate to the service needs of their locality, provision of primary care and therapeutics and those activities necessary to assist consumers in gaining and maintaining access to medical care and therapeutic agents, *including consumer treatment education.* *Terje — the language should require local grantees to ensure that resources are available for consumer education* (p. 229, transcript #2) It is recognized that social service activities supported by the Act should actively assess the involvement, access and barriers to access to health care of clients. Such social services should seek to voluntarily connect into health care those not currently accessing it, while respecting client choice and autonomy around care decisions. A reauthorized CARE Act should continue to recognize that, in many instances, a variety of supportive services may be necessary to connect and maintain people in health care. Provision and/or coordination of those essential services must continue to be part of a CARE Act.	✓

12. Early intervention certification requirement — *All Titles* (p. 140-141, 159-160)

As a condition of award, Title I, Title II, Title III and Title IV grantees should be required to certify and demonstrate appropriate linkages with the appropriate HIV detection, early intervention services, prevention, surveillance, and substance abuse treatment in their jurisdictions. Specifically this should include documentation of ties to local counseling/testing programs and, for governmental grantees, cooperation and planning with those agencies responsible for counseling/testing.	✔

13. Serving vulnerable populations — Title I and Title II (p. 177-178, 186-190)

Grantee responsibility for Title I and Title II in the legislation should explicitly include a requirement to assess the needs of vulnerable populations not currently in care and to develop a plan to meet those needs. As a condition of award, grantees must be able to demonstrate that they have meaningful linkages (such as contracts, memoranda of understanding, co-located staff, etc.) with service providers likely to be the point of entry into care for vulnerable populations not currently accessing HIV care (such as: emergency rooms, sexually transmitted disease clinics, migrant health centers, family planning clinics, homelessness service providers, street youth programs, substance abuse treatment programs, etc.). *Such meaningful linkages may not be universal.*	✔

14. Meeting the care needs of HIV+ women (p. 179; 211-215, transcript #2)

In setting service priorities for primary care, all Ryan CARE Act funded grantees should recognize the importance of obstetrical and gynecological services for HIV infected women and address access to those services as part of their access plan.	✔
Title I programs should *include (reflect?) The percentage of women in the local epidemic* ~~have a minimum 25% set aside for programs that serve women and children~~, and these *funds* ~~services~~ should not be solely linked to perinatal services or focused solely on mothers.	✔

15. Title IV - Elimination of research requirement (p. 212-241)

The reauthorized CARE Act should ~~eliminate~~ *change* the *language in* the existing *legislation to state* ~~require~~ that a "~~significant number of~~ women, infants, children and youth who are patients of the applicant will be *offered the opportunity to* participat~~ing~~e in projects of research" *and either accept or knowingly reject that opportunity.* *Terje -- check what Peter meant with this (p. 240)*	✔

16. Dental/oral health care (p. 242-259)

In a reauthorized Ryan White CARE Act, the present program of supporting dental school clinics for care of oral health needs of people with HIV should be retained. Alternative methods of awarding these funds, including requiring competitive proposals, should be considered. In addition, funds should be made available on a competitive basis to support community-based clinics providing dental care for people with HIV, especially in communities without a participating dental school clinic or with high unmet oral health care needs. Such a competitive program should be administered in a manner similar to the existing Title III of the CARE Act. Oral health should remain an allowable service category under other Titles of the Ryan White CARE Act. *Terje – this was passed with the intent of supporting community-based programs and dental schools. I think it does that. Do you want to change any of this language?*	✓

17. AIDS Education and Training Centers (p. 4-27, transcript #2)

The existing mandate for AIDS education and training centers should be altered in a reauthorized Ryan White CARE Act. Specifically, it should no longer be a focus of AETC's "to train the faculty of schools of, and graduate departments and programs of medicine, nursing, osteopathic medicine, dentistry, public health, allied health and mental health practice to teach health professions students to provide for the health care needs of individuals with HIV disease." Instead, this mandate should be replaced with a focus on providing training relevant and appropriate to the needs of providers and HIV positive consumers of health services in the region the AETC operates, with particular priority given to training of providers who will deliver services to Ryan White CARE Act clients, *and to expanding the number of minority providers who provide care to people with HIV/AIDS.* ~~In addition, the AETC mandate should be expanded to include the possibility of involvement in development of training on quality assurance and improvement and program outcome evaluation for Ryan White CARE Act providers.~~	✓

18. ADAP — funding flexibility (p. 27, 30-32, 33, 37, 42-43, 55-58, transcript #2)

The legislation should allow ADAP funds to be redirected by the state grantee to other essential services under some limited circumstances. The current opportunity for ADAP funds to purchase insurance when economically advantageous should be retained. In addition, when ADAP is already able to provide full coverage of the drugs necessary to meet the PHS treatment guidelines for all low-income people *living with HIV* ~~(<300% of Federal Poverty Level)~~ in their state, they should be able to apply for a receive permission from HRSA to apply ADAP funds to other essential HIV/AIDS care activities in their state, *including services that assist people in accessing and maintaining treatment services.*	✓

19. Flexibility to support integration of federally funded prevention, counseling, testing, and early intervention programs (p. 33-35, 39-40, 47-49, 58-63, transcript #2)

A reauthorized CARE Act should include the option of allowing grantees to apply to HHS for authority to combine parts of funding currently received under different titles of the CARE Act with other federal resources (HIV counseling/testing, *substance abuse treatment,* outreach and prevention, STD detection and treatment) in order to enhance early detection and intervention. This flexibility may be as simple as allowing jurisdictions to adjust internal contracting processes and timetables in order to issue jointly funded requests for proposals.	✓

20. Demonstration project authority -- combining multiple funding streams (p. 33-34, 37, 39, 40-41, 47-54, 61-74, transcript #2)

The reauthorized CARE Act should provide authority for HHS to grant waivers to jurisdictions seeking to combine various federal funding steams supporting HIV/AIDS care and services. Such a waiver would allow a state to combine federal and state Medicaid, Medicare, Ryan White CARE Act and, potentially, parts of SAMHSA and CDC funding. Such waiver authority would require submission of an application documenting how such a demonstration project would allow the jurisdiction to provide access and quality care to more individuals with HIV/AIDS. In addition to direct funding for health care, the demonstration project would be required to include access to supportive services enabling a person to enter and remain in care. Such a demonstration project would be required to include a participatory planning process involving people with HIV, members of impacted communities and key service providers. Before including a Title I EMA funding in such a demonstration project, both the chief elected official and the planning council of the affected EMA would need to concur with participation in the process. Funding for a particular Title III, Title IV, or Part F program would only be included in the demonstration project with the consent of the program. *Terje -- need to strengthen language on the participation process and local safeguards*	✓

21. Administrative cost issues — all Titles (p. 129, 131-154, transcript #2)

We recommend that a reauthorized Ryan White CARE Act specify that:	
-- quality improvement activities are a legitimate programmatic cost that should not be counted against the administrative spending limits.	✓
-- evaluation activities are essential to quality programs and grantees should be allowed to devote up to 5% of their total grant to evaluation activities	✓
~~-- a uniform overhead/administrative limit of 10% be imposed on all titles and sub-grantees. An exemption should be made for small organizations (budgets under $500,000), which may be allowed to spend up to 20% of their award to support administrative activities under appropriate circumstances.~~	
Address the need for additional administrative resources in communities and organizations with poor infrastructures where it is essential to the development of services. (p. 154)	

22. All titles — grievance procedures (p. 130, 155-156, transcript #2)

The legislation should require that all grantees funded under the Act establish appropriate procedures allowing consumers of Ryan White CARE Act funded services to pursue grievances against providers. HRSA should be instructed to establish guidelines for these locally run procedures, including standards for informing consumers of grievance rights, encouragement of mediation, rights of all affected parties, and access to external appeal mechanisms.	✓

23. Re-evaluation of current set aside provisions (p. 130, 157-175, 178-192, transcript #2)

A reauthorized Ryan White CARE Act should alter the way in which set aside funds are distributed.	
The 1% of CARE Act funds that currently go to HHS should go directly to HRSA (p. 163-166).	✓
The set aside funds should continue to be available for technical assistance activities, with new emphasis to providing those activities *(to people who might potentially be providers in the future)* in under served and heavily impacted communities. These funds should also be made available to support national and regional efforts to educate consumers about treatment options and access to care.	✓
A new division of these funds should allow for creation of a program of operational/infrastructure improvement grants to ensure start-up and capacity building support is available in severely under served areas lacking currently lacking capacity. Such a program should include authority to make capital improvement grants or loans when needed to develop the physical infrastructure necessary for service provision. These grants/loan should be made available in geographic areas experiencing significant disease burden and lacking in basic infrastructure.	✓
Substitute: *Allow HRSA to make grants of solicit competitive bids to address pressing needs for infrastructure and capacity development.*(p. 178-179, transcript #2)	
The legislation should ensure that those funds set aside for evaluation and administrative activities related to the Ryan White CARE Act are made available primarily for that purpose within the administrating agency.	✓
The legislation should retain the current $25 million cap on spending for SPNS programs, with *additional resources made available for replication of successful care and service models developed through the CARE Act, with funding potentially made available from the balance of the 3%* ~~consideration to allowing the remainder of the 3% to be made available for the activities described above~~.	
All aspects of appropriations for the Ryan White CARE Act should be subject to the set asides specified at the same level.	

24. Evaluation (p. 215-218, transcript #2)

The legislation should reinforce current HRSA evaluation activities by directing HRSA to establish standardized evaluation measures and instruments that will allow for assessment of patient outcome, care processes and client's satisfaction experiences.	✔

25. Quality Improvement (p. 218-222, transcript #2)

Grantees providing clinical care should demonstrate the existence of quality improvement initiatives and linkage to appropriate local HIV training centers to ensure that appropriate clinical standards are implemented.	✔
For non-clinical services, such as transportation and food services that are provided under Titles I and II, grantees should demonstrate efforts to assess the efficacy of services and document steps taken to meet appropriate standards, including an improvement plan, when deficiencies are noted.	✔

Voted Down/Not Accepted:

Title I formula (p. 42; 114-115, transcript #2)

The percentage of the Title I grant awarded competitively should be increased to 66% from the existing 50%. In doing so, HRSA should make awards based on number of factors, including severity of need, prevalence, and the ability of the competitive proposal to bring or maintain people, especially vulnerable populations, in quality care.	✖

ADAP — Minimum drug formulary (p. 141, 160)

A reauthorized Ryan White CARE Act should require HRSA to develop a core or model drug formulary for ADAPs, prioritizing therapeutic drugs to be provided and requiring ADAP grantees to demonstrate their efforts to supply these drugs to people with HIV.	✖

Consortia (p. 223-226, transcript #2)

Any state that has reported at least 1% of the total national AIDS cases should be required to spend 50% of its funds on consortia activities.	✖

Allowable uses of funds Title I and Title II — outreach and counseling/testing programs (p. 141-143, 164-177)

Outreach to people not in care or unaware of their HIV status, including programs to offer counseling and testing to those, should be allowable expenditures under Title I and Title II when prioritized locally as part of a plan to bring vulnerable under served populations into care. Such efforts should be planned and conducted with attention paid to the existing outreach and counseling/testing programs in the jurisdiction, should be offered by culturally competent and appropriate providers for the population being outreached, and should not be allowed to exceed 2.5% of the total award to a jurisdiction. When funded through the Ryan White CARE Act, such programs must offer immediate and seamless transition into early intervention and care programs.	Withdraw

Access to care for HIV infected adolescents (p. 178, 190-212)

In order to ensure that HIV infected adolescents are accessing care, a reauthorized Ryan White CARE Act should: Require Title I and Title II grantees to include youth services in their needs assessment and planning processes, and to assess the degree to which infected adolescents are being adequately served by existing systems of care. Grantees should be specifically encouraged to support "one-stop" multi-disciplinary youth serving programs. Include in Title III and Title IV priority for funding adolescent centered multi disciplinary programs for HIV infected youth and early intervention/detection for youth at high risk for HIV infection.	Dropped

Access to services for HIV infected substance abusers (p. 178)

In a reauthorized Ryan White CARE Act, Title I and Title II needs assessment, prioritization and planning processes should be required to explicitly address the degree to which services are available to and accessed by HIV infected substance abusers. Such an assessment should include plans for ensuring that substance abuse treatment is readily available for all infected users who seek treatment.	Dropped

REVISED DRAFT 4:00 pm. 8/23

PROJECT LEAD: AN HIV/AIDS INITIATIVE OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Draft

"HIV/AIDS continues to take a devastating toll throughout the world. In fact, health status data continue to reveal that people of color are affected disproportionately by this disease. I strongly believe that communities and their leaders have a critical role to play in the fight against HIV/AIDS. They must not let the competing challenges that confront their communities or their perceptions of at-risk individuals and how those individuals feel they are perceived limit their ability to address this devastating disease. They must not let the stigma associated with those who are at risk of HIV, distrust of the health delivery system, and belief that enduring pain is good result in consolidation of barriers to entry and retention in care. Project LEAD will foster a focused response though a community-based and public-private sector partnership to work with African American and other minority leaders to develop strategies to impact on this complicated problem."

—U.S. Surgeon General, Dr. David Satcher

THE PROJECT: Project LEAD is a groundbreaking new initiative developed by the Department of Health and Human Services (DHHS) at the direction of the U.S. Surgeon General. As a complement to other DHHS HIV/AIDS programs and activities that address the disproportionate impact this devastating disease continues to have on communities of color, the goal of Project LEAD is to broaden the discussion of HIV/AIDS within the African American and other minority communities and to energize and engage minority community leaders to dialogue, identify solutions for change, and implement those solutions in their communities. Change must be effected in communities of color - both in how the leadership perceives at-risk individuals and how those individuals feel they are perceived, commitment must be rejuvenated across the public and private sectors, and the fight against HIV/AIDS must be addressed community by community, neighborhood by neighborhood. The health of minority communities across the nation is dependent upon the effectiveness of this critical partnership. Project LEAD seeks to provide a range of opportunities for minority leaders to join the fight against this devastating disease in the communities where they work and serve.

To develop an effective response, it is necessary to recognize and place in context the often complex interactions between cultural, political, and economic factors that impact on the delivery of HIV-related services and their utilization. Project LEAD will explore a wide range of options to mobilize an effective response to the HIV epidemic among African Americans and other minorities.

Project LEAD is built on the philosophy that communities and their leaders know best what their needs are and the activities that best address those needs, and that community-focused public-private sector partnering is essential. Project LEAD is designed to increase the participation of leaders – those in official positions and those indigenous movers and shakers who set expectations in the community – in educating and enhancing their communities' efforts to address the HIV/AIDS crisis.

The Surgeon General will dialogue with and assist organizations to:

- Convene a series of meetings with community leaders and with organizations that are interested in and committed to increasing HIV/AIDS awareness, treatment, and prevention to encourage dialogue, education, and action on HIV/AIDS in communities of color.

- Build and support networks of health professionals, academics, and community leaders to increase the availability of technical assistance resources and enhance HIV/AIDS programs that serve communities of color.

- Assist Historically Black Colleges and Universities (HBCUs) and other institutions of higher education to take a more active role in working in HIV/AIDS education, outreach, and research.

- Create venues for public interaction with community leaders to dialogue and plan action planning through national and local conferences, town hall meetings, media outlets, satellite broadcasts, and the Internet.

- Assist communities building community-focused public-private sector partnerships.

BACKGROUND: From earliest days HIV disease has been viewed through cultural lenses of attitudes towards sexual orientation. In communities of color, homosexuality has carried tremendous stigma that extends beyond homosexual and bisexual individuals to affect their entire families. The powerful social forces of shame and fear of isolation have made it difficult for minority leaders to identify and address the HIV epidemic in their midst and to mount effective prevention strategies. The concurrent devastation caused by illegal drug use in many African American and other minority communities affects the ability of families to tolerate these behaviors which also increase the risk of HIV. There are dual currents of resentment: at the drug user for bringing stress into the home and at the Government for not working hard enough to eradicate the menace of drug use in the community.

Historical distrust of the medical system, including the effects of new HIV therapies and a fear of being experimented on are deep-seated perceptions that also condition the frequency and quality of primary care and services sought by people of color. A considerable number of African Americans and other minorities chose natural holistic and allopathic therapies over, or in addition to, other treatments.

Another factor for some individuals, related in part to competing life priorities and accessibility of services, is the pattern of enduring ill health and physical symptoms for long periods without engaging the medical systems.

What began as a disease considered to be closely associated with the gay white community has become a disease that has continued to spread rapidly within communities of color. The rates of new HIV infections and mortality rates for minority men, women, and children continue to increase at an alarming pace. **[Insert statistics here.]** This health crisis demands urgent and sustained leadership from within communities of color.

Leaders of the Congressional Black Caucus (CBC) have cited the need for a focused response that both takes stock of current programs and resources dedicated to HIV/AIDS and develops effective strategies to reduce and prevent the heavy toll of HIV/AIDS on the African American and other minority communities. Through the leadership of the CBC and other community leaders, the level of discussion and ownership of HV within minority communities has grown. Project LEAD will build on this leadership.

CONTACT INFORMATION: For more information on Project LEAD, please contact Miguel Gomez, Senior Policy Analyst, under the direction of Eric P. Goosby, M.D., Director, Office of HIV/AIDS, at (202) 690-1194.

THE AFRICAN-AMERICAN AIDS POLICY AND TRAINING INSTITUTE
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Los Angeles, California 90027-1409
VOICE (323) 663-4194 • FAX (323) 666-8846

October 13, 1999

Sandra McDonald, President
Outreach Inc.
825 Cascade Avenue, SW
Atlanta, GA 30311

Dear Sandra;

On behalf of the African American AIDS Policy and Training Institute, I am pleased to forward to you a copy of the first draft of the NIA Report: A National African American HIV/AIDS Strategic Action Plan for your review and comment.

As a recognized advocate and leader in the South on the battle against HIV/AIDS, it is important to have your support and input in this endeavor. The NIA Report is a response to a call for a national Black HIV plan made in February at the National African American Conference in Washington D.C. The new millennium will be upon us in less than 100 days. AIDS continues to run rampant in our communities and many African American Stakeholders are not sufficiently involved in fighting HIV/AIDS.

This draft of the report is being circulated to African American Stakeholders, AIDS activist, community based organizations, academics and government officials for feedback, comments and recommendations. There are a number of gaps in this draft and we need your help in filling in the blanks. We particularly need your help in the Implementation and Recommendation sections. Please note that the Model Programs, Prevention Plan, Treatment Plan and the Research Plan have not been done yet.

- If you are aware of any local adherence, clinical, prevention and/or treatment programs targeting Black Americans that could be duplicated in other communities and should be included in the model programs section, please forward a description of the program along with the contact information to us.

- As someone committed to the health and well being of Black Americans, we would like to know what you think are the elements that must be included in a National Black HIV/AIDS Treatment, or Prevention Plan. Is there a Black HIV Research agenda? Are there clinical or behavioral research issues unique to Black Americans? If you think there are, we would love to hear your thoughts on the subject.

The NIA report is meant to be an educational and resource tool to help inform and engage various segments of our communities in the fight against AIDS. We hope that the stories of people living with HIV, the examples of individuals and organizations coming together to form lines of defense against this deadly virus, and the statistics that document the devastation and the health disparities between Black Americans and other racial/ethnic groups will serve as a call to action to everyone interested in the well being of Black communities and families.

The next draft of the report is scheduled to be released on October 25, 1999. In order for your comments to be included in the next version, **we need to receive your feedback by October 22, 1999**. Please mail, fax, or e-mail your comments as soon as possible to:

Lauren Metoyer
AAAPTI
3408 Huxley
Los Angeles, CA 90027-1409
FAX: 323 666-8846
E-mail: Keith Boykin
Boykink@AOL.com
Lauren Metoyer
LMMetoyer@AOL.com

Finally, the Congressional Black Caucus is sponsoring HIV/AIDS Town hall meetings across the country in CBC district. With your living and working in the Atlanta area, with Representatives John Lewis and Cynthia McKinney districts nearby, I know you are interested in receiving information about the meeting in your community. It would be advantageous for all concerned to have your participation and cooperation in this effort. Someone from our office will be in touch with you or feel free to contact Danny Gibson or George Bellinger, Jr. at (323) 663-4194 or e-mail: GibsonDanny@hotmail.com or GeeRafe@AOL.com .

We look forward to receiving your comments and recommendations SOON. Feel free to contact me personally at anytime. I can be reached at (323) 663-4194 or e-mail: Philltracy@AOL.com. Until then, take care of yourself and your blessings.

Yours in the Struggle,

Phill Wils

Phill Wilson
Director, African American AIDS Policy and Training Institute

Enclosure

PW/lm

SAMPLE NONPROFIT

INDIRECT COST PROPOSAL

INDIRECT COST RATE PROPOSAL

Year ended March 31, 1993

INTRODUCTION

__________________________________ is a not-for-profit Community Action Agency located in Raleigh, North Carolina. The Agency administers a variety of programs funded by Federal, State, and local agencies. These programs include Community Services programs, Head Start programs, State Weatherization, and Food Service programs.

COST ALLOCATION METHODOLOGY

This proposal is for a final indirect cost rate based on the Agency's actual costs for its fiscal year beginning April 1, 1992 and ending March 31, 1993. The proposal is based on the Agency's organization-wide audit report (Statement of Functional Expenses--Statement 3) for the year ended March 31, 1993.

This proposal addresses all elements of cost incurred by _____ .. and identifies shared costs that require allocation.

The Agency treats all costs as indirect costs except general administration and general expenses. Joint costs are prorated individually as direct costs to each category and to each award using a base most appropriate to the particular cost being prorated. Therefore, the direct allocation method has been used in allocating indirect costs.

Individual elements of cash have been classified as direct or indirect in accordance with principles contained in OMB Circular A-122, "Cost Principles for Non-profit Organizations."

DIRECT COSTS

Direct costs are costs that can be identified specifically with a project and therefore are charged to that project. The accounting system records these costs as they are incurred within the series of accounts assigned for that purpose and further distribution is not required.

INDIRECT COSTS

Indirect costs are costs incurred for common or joint objectives and therefore cannot be readily and specifically identified with a particular project or activity. These costs are grouped into a common pool and distributed to benefiting activities by a cost allocation process.

COST POOL AND BASE FOR DISTRIBUTION

The Agency has created an Administrative Services Pool consisting of salaries, fringe benefits, and non-salary costs. The Administrative Services Pool is charged with all the indirect costs as defined above. This pool is distributed to the various program activities on the basis of the direct salaries, including vacation, holiday, and sick pay but excluding other fringe benefits expended on those activities. Volunteers for the Head Start program are included in the direct salaries based on Department of Health and Human Services rulings.

The total direct salaries and wages on which this proposal is based is $1,439,051.

INDIRECT COST RATE PROPOSAL
Year ended March 31, 1993

SUPPORTING FINANCIAL STATEMENTS

The Schedule of Total Expenditures (Schedule B) contained in this proposal agrees to the Agency's audit report Statement of Functional Expenses (Total federal expenses) included with this report.

Audit report--Statement of Functional Expenses (Statement 3)–Total federal expenses	$3,176,202
Schedule of Total Expenditures–Indirect Cost Proposal	$3,176,202

SALARIES

Listed below are the positions, functions, and budgeted annual salaries for the people who comprise the Administrative Services Pool. These positions are charged 100% to Administrative Services.

Position	Function	Salary
Executive Director	General Management	$ 52,337
Deputy Director/ Personnel Officer	General Management and responsible for personnel information	33,016
Administrative Assistant to Executive Director	General Management	24,345
Administrative Secretary	Clerical support to the Executive Director and Administrative Assistant	19,222
Finance Officer	Accounting and related activities	29,910
Bookkeeper	Accounting	21,395
Bookkeeper	Accounting	18,654
Bookkeeper/Payroll Clerk	Payroll accounting and general disbursements	16,749
Custodian	Cleaning	2,986
Receptionist	Switchboard	16,756
Total Administrative Services Pool salaries		$235,370

INDIRECT COST RATE PROPOSAL
Year ended March 31, 1993

FRINGE BENEFITS

Fringe benefits associated with the positions within the Administrative Services Pool are as follows:

Payroll taxes:		
FICA (actual paid)	$18,006	
N.C. Unemployment (actual paid)	687	$18,693
Hospitalization and Life Insurance (actual paid)		18,813
Retirement Plan (actual paid) (4% of applicable salaries)		6,745
Total		$44,251

A copy of the Agency's fringe benefit policies is attached.

NON-SALARY COSTS

Each category of non-salary expenditures has been analyzed based on the facts, and Schedule C shows the allocation between the direct and Administrative Services Pool. Total non-salary direct costs excluding indirect cost reimbursements are $1,426,071 of which direct is $1,342,253 and administrative services is $83,818.

COMPUTATION OF INDIRECT COST RATE - FINAL

Schedule A attached shows the computation of the final indirect cost rate for 1992/93. A summary of this calculation follows:

Administrative Services salaries	$235,370
Administrative Services fringe benefits	44,251
Administrative Services non-salary costs	83,818
Less: adjustments	(1,369)
Total Administrative Services	$362,070

Direct salaries:	
Direct salaries–Schedule B	$1,203,681
Contributed services of volunteers–Schedule B	114,749
Total direct salaries	$1,318,430

Adjusted indirect costs (above)	$ 362,070	=	27.5%
Total direct salaries (base)	$1,318,430		

Schedule A

INDIRECT COST RATE PROPOSAL
Year ended March 31, 1993

	Total Salaries	Total Administrative Expenses	Less Adjustment	Adjusted Indirect Cost
FUNCTIONAL GROUPINGS (See Schedule of Total Expenditures)				
Direct costs: (Salaries including volunteers)				
Community Services Block Grant	$ 162,706			
Head Start	1,134,803			
Weatherization	20,921			
Auxiliary	-			
Total direct salaries	$1,318,430			
Indirect costs:				
Management and General		$363,439	$1,369	$362,070

COMPUTATION OF INDIRECT COST RATE: (1992/93 FINAL)

$$\frac{\text{Adjusted Indirect cost}}{\text{Adjusted direct cost salaries}} \quad \frac{\$\ 362{,}070}{\$1{,}318{,}430} = \underline{27.5}\%$$

Schedule B

INDIRECT COST RATE PROPOSAL

Total Expenditures
Year ended March 31, 1993

	Community Services	Head Start	Weatherization	Auxiliary Fund	INDIRECT COST Management & General	Total
ELEMENTS OF COST						
Salaries and wages	$ 162,706	$ 1,020,054	$ 20,921	$ -	$ 235,370	$ 1,430,051
Payroll taxes	13,081	83,296	1,673	-	18,693	116,743
Group insurance	19,647	135,869	2,049	-	18,013	176,578
Retirement	3,342	7,326	346	-	6,745	17,759
Contractual services	4,897	177,668	48,049	-	-	230,614
Telephone	5,679	18,693	305	46	8,162	33,085
Occupancy	37,454	119,770	-	13,648	3,020	173,892
Equipment rental and maintenance	278	5,553	-	871	5,338	12,038
Equipment/tools purchased	1,049	23,525	546	4,087	1,291	30,498
Renovations and improvements	-	22,853	-	-	-	22,853
Office supplies and expense	2,609	12,300	4,260	682	13,202	33,053
Program supplies and materials	1,376	110,430	54,989	12,117	3,122	182,004
Economic development payments	31,114	-	-	-	-	31,114
Emergency assistance payments	134,550	-	-	62,436	-	196,986
Child and parent services	-	153,948	-	-	-	153,948
Food costs	-	153,847	-	-	-	153,847
Travel	3,673	12,547	-	-	1,642	17,862
Vehicle expense	4,599	38,751	3,634	-	1,596	48,570
Insurance	485	8,445	-	227	3,808	13,965
Professional fees	-	-	-	-	33,045	33,045
Other expenses	4,297	19,656	1,325	23,797	9,592	58,667
Total federal expenses	431,024	2,125,731	138,097	117,911	363,439	3,176,202
DIRECT COST ADJUSTMENTS						
Add: Contributed services	-	114,749	-	-	-	114,749
Less: Equipment/tools purchased and renovations	(1,049)	(46,378)	(546)	(4,087)	(1,291)	(53,351)
Less: Unallowed expenses included in other expenses						
Interest	-	-	-	-	(78)	(78)
Adjusted costs	$ 429,975	$ 2,194,102	$ 137,551	$ 113,824	$ 362,070	$ 3,237,522

Schedule C
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NON-SALARIED COSTS
Year ended March, 31, 1993

Expenditures	Total	Direct	Administrative Services Pool	Explanation of Administrative Services Pool
Telephone	$ 33,085	$ 24,923	$ 8,162	Basic services allocated on number of instruments, toll calls charged on basis of logs of such calls for administrative services.
Contractual services	263,659	230,614	33,045	Accounting and audit services, and payroll processing services, charged on work performed for administrative segvices.
Occupancy	173,892	170,872	3,020	Central office repairs and utilities on basis of square footage used for administrative services.
Equipment rental and maintenance	12,038	6,700	5,338	Rental and maintenance on equipment used in central office and finance office.
Equipment purchased	30,498	29,207	1,291	Purchase of office furniture for use in performing administrative services.
Renovations and improvements	22,853	22,853	-	
Supplies and materials	215,087	198,763	16,324	Office and janitorial supplies for administrative purposes.
Emergency assistance payments	196,986	196,986	-	
Economic development payments	31,114	31,114	-	
Vehicle expense	48,570	46,974	1,596	Gas, oil, repairs, and insurance on vehicles used in operation. Charged based on actual administrative use of vehicles.

NON-SALARIED COSTS
Year ended March, 31, 1993

Expenditures	Total	Direct	Administrative Services Pool	Explanation of Administrative Services Pool
Travel	$ 17,862	$ 16,220	$ 1,642	Mileage, transportation, and per diem associated with administrative services.
Food costs	153,847	153,847	-	
Child and parent services	153,948	153,948	-	
Other expenses	72,632	59,232	13,400	Printing, insurance on personal property, bonding, publications, subscriptions. Based on administrative services' actual use.
Total	$ 1,426,071	$ 1,342,253	$ 83,818	

OMB Circular A-122, subparagraph B.21.c.(2) requires that nonprofit organizations submit, as part of their indirect cost proposals, a certification that the requirements and standards of paragraph B.21 have been met. This certification must be signed either by the official having the authority to negotiate indirect cost rates on behalf of your organization or by a higher level official. The certification should be worded along the following lines:

LOBBYING COST CERTIFICATION

I hereby certify that the (name of organization) has complied with the requirements and standards on lobbying costs in paragraph B.21 of OMB Circular A-122 for the fiscal year ending (fiscal year covered by the indirect cost proposal).

____
Signature

____
Name

____
Title

____
Date